Laboratory and Pathology Payment Policy

Applies to the following Tufts Health Plan products:

☑ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)$^1$
☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting independent laboratory providers and providers rendering laboratory services. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

In addition to the specific information contained here, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers medically necessary laboratory and pathology services, in accordance with the member’s benefits.

Note: Compensation for procedures that are part of laboratory quality control are not covered by Tufts Health Plan.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider website or by contacting Commercial Provider Services.

Note: Tufts Health Plan aligns with the scope of practice for pathologists as defined by CMS. Refer to the CMS website for information on CPT/HCPCS procedure codes included in the scope of practice for pathologists.

PREVENTIVE SERVICES

Due to the Patient Protection and Affordable Care Act (commonly referred to as federal health care reform), with the exception of groups maintaining “grandfathered” status, all Tufts Health Plan plans are required to provide 100% coverage for preventive care services (i.e., no member cost-share). Grandfathered groups are not subject to this requirement, but many of these groups have opted to cover preventive services with no cost sharing.

This means that most members will have no cost-sharing responsibility when preventive services are rendered by an in-network provider. Members may still be required to pay a copayment, deductible or coinsurance for preventive services received from out-of-network providers (PPO and POS plans), or for nonpreventive services received in conjunction with a preventive services visit. Please refer to the Preventive Services list for a complete list of services that have been deemed preventive in nature.

AUTHORIZATION REQUIREMENTS

Referrals are not required for most lab or pathology services; however, a medical requisition form or prescription is required from the requesting provider to in order to direct the member to the appropriate lab, as well as perform medically necessary services.

Note: Genetic testing requires prior authorization. Authorization requests must be faxed to the Precertification Operations Department at 617.972.9409 within 14 days of drawing the blood sample. Refer to the genetic testing medical necessity guidelines for more information on specific genetic testing procedures.

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$^1$ Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
BILLING INSTRUCTIONS

- Append modifier 26 to indicate professional components and/or modifier TC to indicate technical components that require the use of a modifier whether in an office, inpatient or outpatient setting.
  **Note:** Procedures defined as professional or technical component only in nature do not require a modifier and therefore should not be billed with modifier 26 or TC. Refer to the CMS’s National Physician Relative Value File for additional information.

- Submit multiple same-day services on one line; the number of services/units should reflect all services rendered.
- Submit original claims only once; additional submissions of the same claim will result in a duplicate denial. Refer to Avoiding Administrative Claim Denials for additional information.

- Tufts Health Plan does not add procedure codes on claims submitted for laboratory services.
- Submit the most current industry-standard codes; inappropriately coded claims will be denied.

COMPENSATION/REIMBURSEMENT INFORMATION

In accordance with CMS’ CLIA guidelines, Tufts Health Plan requires providers to be appropriately certified to perform laboratory services that require CLIA certification.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Tufts Health Plan may hold the treating provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

**Note:** Contracting laboratories may have a capitation agreement with Tufts Health Plan for services to be performed for a specific provider unit.

Urine Drug Testing

Tufts Health Plan provides coverage for urine drug testing when billed with the procedure codes outlined in the Urine Drug Testing Coverage Guidelines. Coverage is also provided for G0659 when billed in accordance with CMS guidelines.

**Note:** All urine drug tests should be performed at an appropriate frequency based on clinical needs. The frequency should be at the lowest level to detect the presence of drugs.

Tufts Health Plan does not routinely compensate for more than the following within a 365-day period per member, as they exceed clinical guidelines:

- 80305-80307, 80375-80377 (qualitative drug screen) if billed with any combination of more than 20 units
- G0480-G0483 (drug confirmation) if billed more than 10 units

Tufts Health Plan does not routinely compensate for urinalysis (81000-81003, 81005, 81099), creatinine (82570), pH; body fluid (83986) or spectrophotometry (84311) when billed with the following toxicology procedure codes:

- Presumptive drug screen (80305-80307)
- Definitive drug testing (80320-80377, 83992, G0480-G0483)

In-Office Tests

Providers affiliated with a provider organization of a Commercial HMO member’s PCP will be compensated a fee of $5.62 per test subject to the following limits:

- Providers will be compensated for one test for an adult member and up to three tests for a pediatric member (up to age 12) per office visit.
- Compensation will be subject to withhold at the contractual rate.

Providers not affiliated with a provider organization of a Commercial HMO member’s PCP will be compensated in accordance with contracted rates. Physicians will be compensated in accordance with their contracted rates for non-HMO products.

Reduced and Discontinued Services Modifiers

Tufts Health Plan does not compensate for any laboratory panel code billed with modifiers 52 or 53.
**Bacterial Vaginosis Screening**
Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate bacterial vaginosis testing (82120, 83986, 87210, 87510, 87660 or 87905) if billed and the only diagnosis is normal pregnancy.

**Benign Paroxysmal Positional Vertigo (BPPV)**
Effective for dates of service on or after July 1, 2019, Tufts Health Plan will not routinely compensate 80047-89398 (lab tests) if the only diagnosis on the claim line is benign paroxysmal positional vertigo.

**Colorectal Cancer Screening Tests (DNA-based)**
Tufts Health Plan will not routinely compensate 81528 (oncology colorectal screening) if billed without a colorectal cancer screening diagnosis or if the patient's age is greater than 85 years on the date of service.

Effective for dates of service on or after July 1, 2018, Tufts Health Plan will not routinely compensate 81528 (oncology colorectal screening) if billed and the member is less than 50 years of age on the date of service.

**Diagnosis Limitations**
Tufts Health Plan does not routinely compensate for EGFR gene analysis, common variants if billed without a diagnosis of malignant neoplasm of the trachea, bronchus or lung, malignant neoplasm of the pleura, or malignant neoplasm of the brain.

**Duplicate Services**
Tufts Health Plan does not compensate duplicate claim lines reported by an independent laboratory when billed by a different Tax ID, any provider ID or any specialty.

Effective for dates of service on or after July 1, 2019, Tufts Health Plan will not routinely compensate duplicate drug codes if the same code with the same units has been billed on a different claim by any provider for the same date of service.

**Fecal Occult Blood Tests**
Tufts Health Plan does not routinely compensate for 82270 or 82274 (fecal occult blood tests) if billed more than once in a period of three consecutive days.

**Genetic Testing**
Tufts Health Plan limits the coverage of genetic testing procedures for inherited conditions to once in a member's lifetime.

Tufts Health Plan does not routinely compensate for the following:

- Genetic testing procedures if billed with a Tier 1 molecular pathology procedure
- BRCA 1, BRCA 2, gene or full sequence analyses, common duplication/deletion variants or BRCA 2 gene or full sequence analyses when billed if any of these codes has been previously paid for the same date of service.

**Genital Herpes Screening**
Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate 86696 (antibody; herpes simplex, type 2) if billed for a member 13 years of age or older on the date of service and the only diagnosis is a screening diagnosis code.

**Helicobacter pylori (H. pylori)**
Tufts Health Plan does not routinely compensate for 78267, 78268, 83009, 83013, 83014, 86677, 87338, or 87339 if billed more than once every eight weeks (56 days).

**Human Immunodeficiency Virus (HIV) Testing**
Tufts Health Plan does not compensate for human immunodeficiency virus testing if billed without a covered diagnosis.

**Human Papilloma Virus (HPV) Testing**
Tufts Health Plan does not routinely compensate for the following:

- 87623 (infectious agent detection by nucleic acid [DNA or RNA]; HPV low-risk types) when billed
• 87624-87625, 0500T\(^2\) or G0476 for a female member less than age 30 on the date of service if the only diagnosis is a screening diagnosis code
• G0476 (HPV screening) if billed and the member’s age is less than 30 years or greater than 65 years on the date of service
• G0476 if billed by any provider more than once every five years\(^3\)

Effective for dates of service on or after October 1, 2018, Tufts Health Plan will not routinely compensate HPV testing (87624-87625, 0500T, G0476) if billed more than once in a five-year period by any provider for a female member between 30 and 65 years of age on the date of service if the only diagnosis is a screening diagnosis code.

**Incomplete Laboratory Panels**
Tufts Health Plan does not routinely compensate for the following tests when submitted on the same date of service, as additional laboratory components of a panel are included in the price of the laboratory panel code itself:
• More than two basic metabolic panel procedure codes
• More than one of the following procedure codes (82040, 82247, 84075, 84450, 84155, 84460) when billed with a basic metabolic panel procedure code
• More than three comprehensive metabolic panel procedure codes
• More than two electrolyte panel procedure codes
• More than two hepatic function panel procedure codes
• More than three renal function panel procedure codes

**Lipid Panel Testing**
Tufts Health Plan does not routinely compensate for a lipid panel test more than two times within a 365-day period. Refer to CMS for more information.

**Natriuretic Peptide**
Tufts Health Plan will not compensate for natriuretic peptide if billed more than four times per year

**Nuclear Matrix Protein 22 (NMP22)**
Tufts Health Plan does not routinely compensate for immunoassays for tumor antigen, qualitative or semi-quantitative if billed with nuclear matrix protein 22 (NMP22) for the same diagnosis.

**Presumptive and Definitive Drug Testing Frequency**
Effective for dates of service on or after January 1, 2019, Tufts Health Plan does not routinely compensate presumptive (80305-80307) or definitive (G0480-G0483, G0659) drug testing when billed more than one combined unit per day.

**Preventive Services**
Tufts Health Plan does not routinely compensate for a Pap screening when billed with a preventive medicine service by the same provider on the same date of service. Refer to CMS for additional information.

**Prostate-Specific Antigen Testing**
Tufts Health Plan does not compensate for prostate specific antigen (PSA) testing more than once per year under the following conditions:
• If billed more than once per year with the diagnosis indicative of lower urinary tract signs and symptoms by any provider.
• Unless there is a change in the patient’s medical condition. Refer to the CMS Internet-only manual for more information.

**Serum**
Tufts Health Plan does not routinely compensate for aluminum (82108) or ferritin (82728) if billed more than once in a 90-day period and a diagnosis of ESRD is on the claim.

**Surgical Global Services**
Tufts Health Plan does not routinely compensate for the additional surgical service, procedure code 36415 (venipuncture), when billed with an office setting place of service, as the venipuncture is included

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\(^2\) Effective for dates of service on or after January 1, 2019.
\(^3\) Effective for dates of service on or after July 1, 2019.
as part of the global surgical package of the initial surgical procedure. Refer to CMS’ list of 90-day surgeries for additional information.

**Surgical Pathology Diagnosis Limitations**
Effective for dates of service on or after July 1, 2019, Tufts Health Plan will not routinely compensate surgical pathology gross & microscopic exams (88305, 88307 or 88309) if the only diagnosis on the claim line is any of the following:

- Appendix
- Cornea
- Gallbladder
- Ganglion cyst
- Hemorrhoid
- Hydrocele or spermatocele
- Polyp of stomach and duodenum

**Vitamin D Testing**
Tufts Health Plan does not compensate for 82306 (vitamin D; 25 dihydroxy) if billed without a requisite diagnosis code or if billed more than four times per year for the diagnosis of vitamin D deficiency.

**ADDITIONAL RESOURCES**
- Outpatient Behavioral Health and Substance Use Disorder Payment Policy
- Pharmacy Medical Necessity Guidelines: Opioid Dependence Medications

**DOCUMENT HISTORY**
- May 2019: Added claim edits for benign paroxysmal positional vertigo (BPPV), surgical pathology, and duplicate drug codes, effective for dates of service on or after July 1, 2019
- November 2018: Added claim edits for bacterial vaginoses screening; HPV testing; and presumptive and definitive drug testing, effective for dates of service on or after January 1, 2019
- August 2018: Added claim edits for genital herpes screening, human papilloma virus (HPV) testing effective for dates of service on or after October 1, 2018
- June 2018: Template updates
- May 2018: Added claim edit for DNA-based colorectal cancer screening, effective for dates of service on or after July 1, 2018; clarified urine drug testing compensation information
- April 2018: Clarified existing urine drug testing guidelines
- February 2018: Added claim edits for colorectal cancer screening tests, effective for dates of service on or after April 1, 2018
- November 2017: Added edits for duplicate claim logic for independent laboratory services, human papilloma virus (HPV) testing, urine validity and drug testing, and vitamin D testing effective for dates of service on or after January 1, 2018
- September 2017: Policy reviewed by committee; added pathology content to policy to combine
- July 2017: Added edits for screening for cervical cancer with HPV testing
- March 2017: Added protein testing codes G0480-G0483, G0659
- February 2017: Added clarification of age limit for pediatric in-office tests
- January 2017: Updated codes. Added urine drug testing codes 80305-80307 effective for dates of service on or after January 1, 2017; removed inactive HCPCS codes G0477, G0478, G0479 (end-dated 12/31/2016) and G6058 (end-dated 12/31/2015).
- May 2016: Added previously implemented edits for HIV testing and prostate specific antigen; added genetic testing and laboratory claim edits, effective for dates of service on or after July 1, 2016
- January 2016: Deleted procedure codes G0431 and G0434 as they were end dated as of 12/31/15, added new codes G0479, G0477 and G0478, added new policies for genetic testing and laboratory procedures, effective April 1, 2016, template updates
- November 2015: Added change to recoding policy, effective for dates of service on or after January 1, 2016
- September 2015: Template conversion, template updates
- July 2015: Added genetic testing policy effective for dates of service on or after October 1, 2015, template updates
January 2015: Added new HCPCS procedure code G6058 and CPT procedure codes 80375, 80376 and 80377, removed procedure code 80102 as it was end dated 12/31/2014
October 2014: Policy reviewed, no content changes, template updates
November 2013: Added information on urine drug testing, effective for dates of service on or after January 1, 2014, template updates
July 2013: Template updates
April 2012: Template updates
March 2012: Updated CareLink disclaimer language
December 2011: Policy reviewed, minor content changes
November 2011: Template updates, no content changes
September 2010: Added information regarding Preventive Services
February 2010: Added effective for claims adjudicated on or after April 1, 2010, Tufts Health Plan will not compensate for a lipid panel test more than two times within a 365-day period.
November 2009: Added Effective for claims adjudicated on or after January 1, 2010, Tufts Health Plan will not compensate for more than two hepatic function panel procedure codes when submitted on the same date of service. Removed laboratory-diagnosis code combination information effective for claims adjudicated on or after July 1, 2009. These edits are no longer effective.
August 2009: Added incomplete laboratory panel and recoding information effective for claims adjudicated on or after October 1, 2009.
May 2009: Added laboratory-diagnosis code combination information effective for claims adjudicated on or after July 1, 2009
February 2008: Revised general benefit information with self-service channels information

AUDIT AND DISCLAIMER INFORMATION
Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLinkSM for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.